

Mississippi 's Plan to Eliminate Racial & Ethnic Health Care Disparities

Mississippi State Department of Health

**Office of Minority Affairs
&
Disparities Steering Committee**

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Mississippi 's Plan to Eliminate Racial & Ethnic Health Care Disparities

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Abstract

An Overview of the Problem

Mississippi public health officials have long recognized the health care needs of minorities that result from poverty, influx of large minority groups, lower educational levels, and limited health manpower, particularly in rural areas. Private physicians in Mississippi are often unaware of the services available through the local public health departments, and public health officials are not aware of the physicians' interest in the health of minority communities. The issue of healthcare disparities is receiving attention at the national and state levels; substantial differences in health care still exist among racial and ethnic groups. Policy makers realize that, ultimately, healthcare disparities impact all citizens by decreasing their quality of life. Some of the differences in the health of racial and ethnic groups can be explained by the differences in their experiences within the health care system.

In 1998, the former President Clinton identified six areas of healthcare disparities: cardiovascular disease, diabetes, cancer screenings, HIV/AIDS, child/adult immunizations, and infant mortality. These six areas were selected for emphasis because they reflect areas of disparity that are known to affect multiple racial and ethnic minority groups at all life stages. Mississippi's Plan to Eliminate Racial and Ethnic Health Care Disparities will strengthen and enhance Healthy People 2010, the Nation's health objectives for the 21st century, for which eliminating disparities is an overarching goal. Funding for the development of this Plan was provided by the Federal Office of Minority Health, Department of Health and Human Services.

Process Used to Develop the Plan

A series of community forums, designed to collect information from those most affected, were conducted throughout the state. Citizens participated in sharing pertinent issues affecting the level of health care received by nonwhite ethnic groups, primarily African Americans. The issues they identified are presented in this report. In addition, a State Health Care Disparities Steering Committee consisting of health care providers, consumers, community-based organizations (CBOs), other state agencies, colleges/universities, service groups and advocates was created to provide guidance and direction on the overall development of this Plan.

How the Plan Will Be Used

The result of this concerted effort is a comprehensive *Mississippi Plan to Eliminate Racial and Ethnic Health Care Disparities*, which includes input from citizens representative of the population residing in Mississippi. The Plan is believed to be realistic and achievable based on the state's currently available resources. Eliminating healthcare disparities in Mississippi will improve the quality of life for all citizens.

When funding becomes available, implementation will proceed on the strategies outlined. However, strategies such as capacity building, promoting culturally appropriate and linguistically accessible services, providing reference and resource information on minority health issues to Mississippi citizens, and more comprehensive community health planning will be implemented by existing staff when feasible.

Emerging Issues and Discussion of the Strategies

Based on the data collected from the forums, the following issues emerged: *cultural competency*, *prevention/education*, *accessibility/availability*, *funding/finance*, and *legislation*. Strategies, action steps and desired outcomes have been developed, and the State Health Care Disparities Steering Committee will begin to address these areas. These strategies include, but are not limited to, the creation of public/private partnerships to provide health insurance coverage, increasing the number of under-represented minorities in Mississippi's health professions, increasing the number of medical/health care consumers on provider boards, increasing/enhancing community health education outreach activities of hospitals and state operated and/or funded health care agencies, and preparing medical and other health care and human service professionals for cross-cultural relationships with their patients. Action steps to facilitate these strategies include, but are not limited to, creating partnerships with other state entities, i.e., the Department of Education, Mississippi Division of Medicaid, University of Mississippi Medical Center and State Institutions of Higher Learning as well as faith-based agencies, community-based organizations (CBOs), healthcare provider groups, and community groups and healthcare advocates; and institutionalizing policies and practices to strengthen the ability to fully serve and effectively address the health care needs of all citizens in the state.

TABLE OF CONTENTS

Abstract

Overview of U.S. Health Disparities Status 3-

16

Overview of Mississippi Health Status 1 6 -

28

The Mississippi Health Care Disparities Elimination 2 8 -

45

References 46

Appendix 47

OVERVIEW OF HEALTH DISPARITIES IN THE UNITED STATES

Health care for the United States population overall has improved over the past few decades. All Americans, however, have not shared equally in the improvements. Despite many recent improvements in the health of Americans, substantial differences still exist among racial and ethnic groups. Some of the differences in the health of racial and ethnic groups can be explained by the differences in their experiences within the health care system. A report by the Medical Expenditure Panel Survey (MEPS) conducted in 1996 presents estimates of health insurance coverage, access to health care, and health status for Hispanic, African Americans, and white Americans. The findings indicate that Hispanics of all ages were the most likely to be uninsured with nearly three in ten Hispanic children having no insurance coverage. African Americans were less likely than whites to have private health insurance, but they were more likely to be publicly insured. Hispanics were more likely than others to have a hospital-based usual source of care. African Americans and Hispanics were less likely than whites to be in excellent health and more likely to be in fair or poor health.

Mortality is a crude indicator of health status, but it demonstrates how critical the disparities are for racial and ethnic minorities. The disparities begin early in life and continue throughout the life course. African American infant mortality rates are more than double that of whites (14 percent vs. six percent), while Native American infant mortality rates (10 percent) are more than one and a half times those of whites. Among adults, the death rate for African Americans is approximately 55 percent higher than whites; for American Indian/Alaska Natives it is more than twice the rate of whites, and the death rate for Hispanics is more than one and a half times the rate for whites (National Center for Health Statistics, 1998).

In recognition of continuing disparities, former President Clinton targeted six health areas and committed resources to address issues in relation to disparities. The targeted areas are cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS and child and adult immunizations.

Cancer

Research indicates that individuals of diverse racial, ethnic, and cultural heritage are less likely to get regular medical checkups and be routinely tested for cancer when compared to whites. Cancer deaths are disproportionately high among Latino/Hispanic Americans and African Americans.

Cardiovascular Disease

Cardiovascular disease, specifically coronary heart disease and stroke, mortality is higher based on race and ethnicity. Mexican Americans have elevated blood pressure rates; rates of obesity are higher for African American and Mexican American women; only 50 percent of African Americans, 44 percent of Native Americans, and 38 percent of Mexican Americans have had their cholesterol checked within the past two years; coronary heart disease mortality is higher for African Americans. Stroke is the only leading cause of death for which mortality is higher for Asian American males.

Infant Mortality

Despite recent advances, African American and Native American babies still die at a rate that is two to three times higher than the rate for white American babies. The incidence of Sudden Infant Death Syndrome (SIDS) for Native American infants is more than three times the rate for white infants, and the gap has widened between mortality rates for African American and white infants.

Diabetes

Approximately 16 million people in the United States have diabetes, making it the seventh leading

cause of death. African Americans, Latino/Hispanic and Native Americans are more likely to have diabetes than white Americans (1.7, 2.0 and 2.8 times, respectively). In addition, Native Americans and African Americans have higher rates of diabetes' related complications such as kidney disease and amputation as compared to the white population.

HIV/AIDS

African Americans and Hispanic/Latinos are disproportionately impacted by this epidemic, especially women and children. African Americans and Hispanic/Latinos comprised 47 percent and 20 percent, respectively, of persons diagnosed with AIDS in 1997. Among African Americans, 56 percent of new HIV infections and AIDS cases are a result of intravenous drug use; for Hispanic/Latinos the percentage is 20 percent. Seventy-five percent of HIV/AIDS cases reported among women and children occur among non- white racial and ethnic groups.

Child and Adult Immunizations

Immunization levels for school age children and elderly adults of non-white racial and ethnic backgrounds continue to lag when compared to the overall vaccination rates of white Americans. Seventy-nine percent of white preschoolers are immunized by two years of age compared to 74 percent of African American and 71 percent Hispanic/Latino children. Annually, approximately 45,000 adults die of infections related to influenza, pneumococcal infections, and hepatitis B despite the availability of preventive vaccines.

The Agency for Healthcare Research and Quality (AHRQ) reports that among non-elderly adults, 16 percent of African Americans are in only fair or poor health, compared to 10 percent of white Americans (AHRQ Fact Sheet, 2000). Other disparities in health care, according to AHRQ, include the following:

- ' 20 percent of African Americans lack a usual source of health care compared with less than 16 percent of whites.
- ' Hispanic children are nearly three times as likely as non-Hispanic white children to have no usual source of health care.
- ' African Americans are far more likely to rely on hospitals or clinics instead of a personal physician for their usual source of care (16 percent), than are white Americans (eight percent).
- ' Minorities are more likely to characterize their health status as fair or poor compared to whites, and women of all races are more likely to be in fair or poor health compared to men.
- ' African American men and women with colorectal cancer have a 50 percent greater probability of dying of colon cancer than white men and women.

According to AHRQ in their study of *Racial and Ethnic Differences in Access to and Use of Health Care Services from 1977 to 1996*, trends were documented in racial and ethnic disparities over a 20-year period. The study reported that “it is clear that disparities in our measures of access and use have not decreased since the Task Force on Black and Minority Health issued its report in 1985”(p.51). In addition, the report concluded that “even if income and health insurance coverage were equalized, differences in access to and use of health care services would not be eliminated, as one-half to three-quarters of these disparities are not explained by these two factors”(p.51). Consequently, researchers are exploring what is described as “more complex explanations” for disparities, including job-related and nonfinancial barriers to access, a lack of cultural and linguistic competency among health care providers and institutions, the geographic distribution of health care providers compared with residential patterns of particular racial and ethnic groups, both intentional and unintentional discrimination within the health care system, and perceptions of discrimination on the part of members of various racial and ethnic groups

(Weinick et al., *Medical Care Research and Review*, 2000, p.51).

ACCESS TO HEALTH CARE

The frequently cited explanation for the disparity in health care for African Americans is “lack of access to quality health care.” The Henry J. Kaiser Family Foundation commissioned a synthesis of the literature on *Racial and Ethnic Differences in Access to Medical Care* in 1999. According to the findings, adolescent and adult African Americans and Hispanics were less likely to have any physician contact over the course of a year when compared to whites. This occurred even after adjusting for health status. Minorities were also less likely to receive a wide range of inpatient and outpatient procedures. Their findings focused on the following areas:

Heart Disease and Stroke

African Americans and Hispanics are significantly less likely than whites to receive diagnostic and surgical interventions for heart disease and stroke, with disparities ranging from 13 to 70 percent. The reasons for these racial disparities in access to services for heart disease and stroke are not understood. However, the overuse of surgical interventions by whites combined with a greater aversion to surgery among African Americans could partially explain the disparity, according to the researchers.

Cancer

Racial and ethnic minorities are more likely to be diagnosed with cancer at advanced stages and less likely to receive major therapeutic interventions. Access for Hispanic women is not equivalent to that of white or African American women. However, African American women still do not take advantage of the access even though it is equivalent, and in some cases, superior to the access for white women.

Diabetes

Racial differences have been documented in the areas of degree and method of diabetes control, attention to patient education, rate of eye care visits, and treatment for end stage renal disease (which can be a consequence of severe and uncontrolled diabetes).

HIV/AIDS

Despite government intervention, disparities continue to exist in HIV/AIDS treatment for minorities. Race appears to be a strong predictor of receipt of drug therapy by African Americans. They are 41 to 73 percent less likely than whites to receive particular drug agents, even after adjusting for age, sex, mode of HIV transmission, insurance, residence, income, and education. In addition, racial and ethnic groups have typically had extremely low participation rates in clinical trials.

Maternal and Child Health

African American and Hispanic females enter prenatal care later than white females and are less likely to receive good advice regarding their pregnancies. African American women are more likely to be hospitalized for antenatal and pregnancy loss complications and are more likely to stay longer. African American infants are admitted to neonatal intensive care units more than two and a half times as frequently as white infants; this disparity is not driven by a greater frequency of low birth weight among African American infants. In addition, African American children typically have poorer access to all types of health care services than white children, a finding that is both exacerbated by and independent of socioeconomic status. Even though the immunization gap between ethnic minority children and white children has narrowed in recent years, African American children in urban areas continue to receive fewer vaccinations than Hispanic children.

Access to Adequate Health Insurance Coverage

Health insurance coverage is central to reducing financial barriers and promoting access to health care services. Lack of health insurance and poor access to timely health services deprive many ethnic and racial minorities of the benefits that regular medical care and preventive health services offer. Disparities in health insurance coverage and access to health care services thus contribute to and exacerbate disparities in health status. These disparities should be a concern to the entire nation because ethnic and racial minorities comprise a growing proportion of the U.S. labor force and of the total population – projected to rise from 28 percent of the population in 2000 to 38 percent in 2025 and 47 percent in 2050 (*Racial and Ethnic Disparities in Access to Health Insurance and Health Care*, UCLA Center for Health Policy Research and The Henry J. Kaiser Family Foundation, 2000).

According to the UCLA and Kaiser Foundation report, job-based insurance coverage increased for many groups as a result of the sustained strength of the economy in the late 1990s that generated improved employment and higher incomes. However, large numbers of persons – particularly those with lower levels of educational attainment – have not received equal benefits from the economy. In addition, the implementation of welfare reform and other policy changes have reduced Medicaid coverage, offsetting the increases in job-based coverage for many persons. Therefore, the recent period of economic growth has been associated with only slight increases in job - based insurance and with greater declines in Medicaid coverage, which combined to drive up uninsured rates.

Additionally, the report revealed that compared to non-Latino whites, all ethnic groups have lower rates of employment-based health insurance and higher uninsured rates. Latinos experience the highest uninsured rates: 37 percent, compared to 14 percent for whites. Latinos are uninsured at such high rates because only 43 percent have employment-based health insurance, compared to 73 percent of whites.

Nearly one in four non-elderly African Americans is uninsured, reflecting low average incomes and low rates of job-based insurance as well as recent declines in Medicaid coverage. African Americans' low incomes and the large proportion who live in single-parent families combine to help explain their higher rates of Medicaid coverage (19 percent vs. six percent for whites) and underscores the important role that Medicaid plays for all low-income American families with children.

Across all ethnic groups, lack of health insurance results in weak connections to the health care system and poor access to health services. Because uninsured persons in fair or poor health visit physicians less often than their insured counterparts, they are less likely to receive care needed to manage their chronic conditions, such as diabetes or high blood pressure. Uninsured children and adults, whether in good or poor health, are less likely to receive preventive health services or care for acute conditions.

For most uninsured persons, low incomes make insurance coverage unaffordable without substantial financial assistance. Public policy could compensate for limitations in the United States' voluntary employment-based health insurance system. Overall, 57 percent of the uninsured are poor or near poor, with family incomes below 200 percent of the poverty level. A national health system that covered the entire population, or even one that mandated all employers to cover those who work for them and their dependents, would address the health insurance needs of this population (UCLA and Kaiser Family Foundation, 2000).

Quality of Health Care

Once African Americans and other ethnic minorities enter the health system, the kind of care received becomes an issue. The availability of insurance coverage should lead to high-quality care.

However, many degrees exist between the availability of insurance and the delivery of high-quality care and between the capacity to serve and the delivery of service that meets people's needs (JAMA, *Transforming Insurance Coverage Into Quality Health Care*, Eisenberg & Power, 2000). Consequently, the disparity issue must be approached with bifocal vision; one focus must be on “*access*” and the other must be on “*quality*” of care received after entry into the system. Racial/ethnic minorities experience worse first contact primary care than whites even after controlling for racial/ethnic disparities in socio-demographic and health-status characteristics (Shi, 1999). According to this research, regardless of socioeconomic status and health condition, minorities do not receive the same quality of health care because of their race or ethnic status. This suggests that racial/ethnic disparity in primary care experience is not simply a straightforward reflection of socio-demographic and health-status differences across racial/ethnic groups. It further suggests that a more complex relationship is involved in the ways in which people of different racial/ethnic backgrounds and the health care system relate to and interact with each other. Therefore, a policy implication is that simply expanding insurance coverage to those without insurance might not overcome the disparity in the quality of primary care received by racial and ethnic group members. Thus, researchers recommend that efforts must also be made to provide ethnically and culturally competent care and the removal or reduction of the many barriers facing racial/ethnic minorities in their access to primary care. This includes assistance in transportation and child care, expansion of office hours, and reduction of waiting time for and during appointments.

According to AHRQ (2001), less than one-half of African Americans and Hispanics feel satisfied with the quality of care they receive (see Appendix, Chart 4-18). The Institute of Medicine estimated that medical errors cause 44,000 to 98,000 deaths per year and would rank as at least the eighth leading cause

of death in the United States (JAMA, Eisenberg & Power, 2000). However, researchers contend that errors are gaining recognition as a means of targeting opportunities for quality improvement rather than as a negative consequence that requires assigning blame. Accountability is necessary to ensure that at least a minimum level of quality is provided, but health care decision makers continue to rely on basic measures of quality to establish a minimum level below which a provider may not be allowed to deliver services and this does not ensure that the care is as good as it should or could be. Eisenberg and Power suggest improvement in quality can be achieved by identifying the current outcomes of the patients served and then introducing evidence-based interventions to improve care while assessing whether outcomes did improve. High-quality health care cannot be realized without addressing the patient's needs. Those needs include satisfying the patient's and the family's desire for information, confidentiality, comfort, and other expectations.

CULTURAL COMPETENCY

There are various definitions of cultural competence. Most definitions encompass the one developed by mental health researchers over a decade ago which defines *cultural competence* as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals,” enabling them to work *effectively* in cross-cultural situations (*Medical Care Research and Review*, 2000, p.182). Ultimately, the effectiveness of services delivered is the most significant factor impacting health care.

The word *cultural* refers to the integrated patterns of human behavior that include thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. The word *competence* is used because it implies having the capacity to function in a particular

way, specifically within the context of culturally-integrated patterns of human behavior defined by the group (U.S. Department of Health and Human Services, Goode, 2001).

Despite similarities, fundamental differences among people arise from nationality, ethnicity and culture, as well as from family background and individual experience. These differences affect the health beliefs and behaviors of both patients and providers. They also influence the expectations that patients and providers have of each other. The delivery of high-quality primary health care that is accessible, effective, and cost efficient requires health care practitioners to have a deeper understanding of the socio-cultural background of patients, their families, and the environments in which they live. Culturally competent primary health services facilitate clinical encounters with more favorable outcomes, enhance the potential for a more rewarding interpersonal experience, and increase the satisfaction of the individuals receiving health care services (AHRQ, *Strategies to Reduce Health Disparities Conference*, 2000). This nation is faced with a challenging opportunity to respond effectively to the needs of all of its citizens – individuals and families from racially, ethnically, culturally, and linguistically diverse groups. This requires an understanding of the importance of culturally competent approaches in all interactions with the public. Cultural competence in primary health care has become the focus of many organizations and programs struggling to accept the challenge before them.

The National Center for Cultural Competence (1999), lists the following justifications for cultural competence in health care at the patient-provider level:

- C The perception of illness and disease and their causes varies by culture;
- C Diverse belief systems exist related to health healing and wellness;
- C Culture influences “help seeking behaviors” and attitude toward health care providers;
- C Individual preferences affect traditional and non-traditional approaches to health care;
- C Patients must overcome personal experiences of biases within health care systems; and

- C Health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system

The justifications listed above make it crucial that all policy-makers buy into the need to address the issue of health care disparities in our nation. “Nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people in the United States” (National Center for Cultural Competence, Policy Brief 1, 1999). Although some progress has occurred in overall national health, disparities continue in the health, illness, and death among African Americans, Latino/Hispanic Americans, Native Americans, Asian Americans, Alaskan Natives and Pacific Islanders when compared to whites.

When the issue of disparity in health care is examined, our perspective must expand if we are to understand the impact on the nation and not just on particular ethnic groups. Many times we do not make sufficient progress because we limit the impact of disadvantages to specific populations. A broadened perspective will allow us to view the real impact, that affects an entire community, a state and ultimately a nation. The inclusiveness of this perspective will allow for development of real solutions designed to bring about change rather than simply funding projects as evidence that efforts have been made. We are *one* nation, therefore the impact on one ethnic group will ultimately affect our total population. Our nation is becoming more diverse and by 2010 it is projected that minorities will constitute 32 percent of the population in the United States (Minority Health Perspective, 2001). By 2050, nearly half of the U.S. population will be composed of members of ethnic and racial minorities. If the U.S. plans to maintain its status among other nations, it can no longer afford to neglect nearly half of its population. Therefore, medical schools must prepare medical students to effectively serve a diverse population. This requires that future medical doctors are trained “to respond to the unique needs of patients from varying ethnicities,

racess, sexual orientations, and cultural backgrounds (Lawler, Minority Health Perspective, 2001).” The goal must be to assure that all health care providers are culturally competent.

The National Center for Cultural Competence (NCCC) argues that “culturally competent methodologies are essential to effectively address the history of mistrust of research.” A primary justification for this perspective is the strong history of mistrust of research within diverse communities, particularly communities of color as well as members of other nationalities. Communities of disenfranchised persons tend to distrust researchers and other professionals (Sierber, 1992). Such beliefs and perceptions have their roots in historical and unfortunately current experiences that members of culturally and ethnically diverse groups have encountered in this nation’s health care delivery systems. Many of these individuals typically view research through a prism of victimization and fear. This mistrust is reinforced by widely publicized research, such as the “Tuskegee Study.” Unfortunately, this study continues to have ramifications on how medical and health care research is viewed among segments of the African American population today (Stevens, 1995, from AHRQ Conference, 2001).

Many public officials, healthcare facilities, and providers are unaware of their obligations to provide culturally appropriate health care to their patients; no universal understanding exists of what “culturally competent” care is, how to measure or evaluate appropriate care, or how to define successful programs. No established standard defines competent care, making it dubious that anyone is really serious or committed to addressing this issue. Although schools of medicine, nursing, and public health offer courses on cultural competency, the quality and depth of the courses vary dramatically from one lecture to another, as well as from one semester to the next.

The conceptual framework of the cultural competence model that is used by the NCCC is based

on the following beliefs:

- ' A defined set of values, principles, structures, attitudes and practices are inherent in a culturally competent system of care;
- ' Cultural competence at both the organizational and individual levels is an ongoing developmental process; and
- ' Cultural competence must be systematically incorporated at every level of an organization, including the policy making, administrative, practice and consumer/family levels.

A “checklist” and a “cultural competence continuum” included in the appendix is designed to help individuals who have a role in the shaping of policy at the federal, state, local, and program levels. The goal is to facilitate policy making that supports culturally and linguistically competent primary health care services (AHRQ Conference, 2001).

OVERVIEW OF HEALTH DISPARITIES IN MISSISSIPPI

During the 1900s, Mississippi’s health status improved significantly. Death rates in the general population and infant mortality rates declined; health care is available to more people; advances in medical knowledge and technology provide more effective management of many diseases. The Mississippi State

Department of Health (MSDH) recognizes that many challenges remain, perhaps the greatest being health care disparities based on statistics.

“Nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people...no matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all. And that is why we must act now with a comprehensive initiative that focuses on health care and prevention for racial and ethnic minorities...(President William Jefferson Clinton, Radio Address to the Nation, February 21, 2000).” “Health care is an ethical and moral matter. Lack of access to adequate health care can restrict an individual’s normal range of opportunities and raises basic issues of fairness and social justice,” states David Barton Smith, author of the book Health Care Divided: Race and Healing A Nation (Ann Arbor, MI: University of Michigan Press, 1999, p.9). A national focus on disparities is particularly important as major changes unfold in the way in which health care is delivered and financed (U.S. Department of Health and Human Services (HHS), “Eliminating Racial and Ethnic Disparities in Health”).”

Mississippi public health officials have long recognized the health care needs of minorities that result from poverty, lower educational levels, and limited manpower, particularly in the state’s more rural areas. In recent decades, the influx of a large population of minority immigrants, particularly Asians and, more recently, Hispanics, has increased the ethnic makeup of Mississippi’s population. “...These disparities are even greater if comparisons are made between each racial and ethnic group and the white population. These disparities are not acceptable (HHS, Office of Public Health and Science, *Healthy People 2010 Objectives*: September, 1998, Goals, pp. 19-20).” In response to this national focus, as well as recognizing the vital urgency of addressing health care disparities in Mississippi, the MSDH is moving

forward to improve the health status of its minority populations.

MSDH COMMUNITY PROGRAMS/COMMITTEES/PROFILES

The mission of the MSDH is to promote and protect the health of Mississippi's citizens. The Department accomplishes its mission through many programs and projects as well as through cooperation with other government agencies and private sector organizations.

The Mississippi State Department of Health supports many projects on the community level and statewide initiatives/committees that address pertinent health care needs of the state's citizens.

Through these avenues, the MSDH provides opportunities for the general public to participate in problem identification and the decision-making processes. Evidence of this is documented by community based programs/initiatives, some of which follow.

HIV/AIDS Programs

Mississippi Community Planning Group for HIV Prevention

The Mississippi Community Planning Group for HIV Prevention (MSCPG), established in January 1994, is Mississippi's only community planning body that addresses HIV. Its' purpose is to assist the Mississippi State Department of Health in its HIV prevention community planning process by developing a comprehensive HIV Prevention Plan for the State of Mississippi. The Mississippi State Department of Health and MSCPG share the responsibility for developing a comprehensive HIV prevention plan with other state and local agencies, non-governmental organizations, and representatives of communities and groups at risk for, or infected with HIV. This type of planning allows input from the populations that are directly impacted by HIV infection (Source: MSDH State Health Plan, 2000).

The following are community-based contractors under the efforts of the Mississippi Community Planning Group for HIV Prevention:

Building Bridges

Goals: To increase public understanding of involvement in and support for HIV and STD prevention, prevent or reduce behaviors and/or practices that place individuals at risk for HIV infections, and to increase knowledge of HIV and STD. The target group is African American women and heterosexuals.

DePorres Health Center

Goals: To increase public understanding of, involvement in, and support for STD/HIV prevention and to prevent or reduce behaviors and practices that place other persons at risk for HIV infection. The target group is African American males and females with HIV/AIDS.

Jackson State University's Mississippi Urban Research Center

Goals: To increase public understanding of, involvement in, and support for STD/HIV prevention and to prevent or reduce behaviors and/or practices that place individuals at risk for HIV infection, or if already infected, place others at risk and to increase the knowledge of STD/HIV of African American men who have sex with other men. The target population is African American males and men who have sex with men.

Greater Mt. Calvary Baptist Church

Goal: To help uninfected African American women initiate and sustain behaviors to reduce their risk of becoming HIV positive. The target population is African American females.

Project Connect

Goal: To reduce the number of new HIV infections among individuals in West Central Public Health District V. The target population is African American men who have sex with men, and heterosexuals.

Our House

Goal: To increase understanding of STD/HIV/AIDS, while facilitating behavior changes aimed at reducing HIV infection and risk reduction in Mississippi Public Health District III and the Mississippi Delta area. The target population is teens and youth.

Mississippi Children's Home Society and Family Service Association

Goals: To increase understanding of HIV/AIDS while facilitating behavior changes aimed at reducing HIV infection and risk reduction among high-risk youth in Central Mississippi and Statewide. The target population is teens and youth.

Not Here Foundation (Women's Project)

Goal: To educate African American women about STDs and HIV/AIDS with group and community level interventions. The target population is African American females and substance users.

South Mississippi AIDS Task Force

Goal: To reduce behaviors in the six counties of the state of Mississippi Coastal Plains Public Health District IX that place persons at risk for contracting or spreading HIV and other STD's. The target group is all populations.

The Mississippi Chronic Illness Coalition

This Coalition is comprised of professionals, private citizens, state agency representatives, and others interested in addressing the issues pertinent to chronic illnesses affecting the citizens of our state. The mission of the MCIC is "to reduce the prevalence, complications, cost and disability attributed to those chronic health problems that have been shown to have the greatest impact on the state's citizens."

The MCIC has five standing committees that exist to support the mission and objectives of the

Coalition.

The five overarching goals are:

- ' Identify existing resources relating to chronic illness throughout the state and coordinate efforts among the resource groups;
- ' Increase chronic illness awareness among all sectors of the population;
- ' Improve access for those with chronic illnesses to health promotion, prevention and treatment programs;
- ' Promote provider education relating to chronic illness throughout the state; and
- ' Gather and disseminate existing data that defines the burden of chronic illness.

Mississippi Breast and Cervical Cancer Program

The central aim of the Breast and Cervical Program is to address the screening needs of those women at highest risk cancer. Typically, these women are the uninsured, the medically underserved, the poor, African American women (and other minorities), and elderly women. These women are more likely to have advanced disease at the time of presentation, reflecting differences in access to screening and care, and fear about cancer or being screened for cancer. The Mississippi State Department of Health Early Detection Services have been made available statewide through funding from the Centers for Disease and Control and Prevention (CDC) and the matching non-federal funds. Pap exam screening services at Mississippi State Department of Health clinics, Community Health Centers (CHC) and private providers are available to uninsured women 18 years of age and older. Mammography screening is available through contract providers to uninsured women 50 years of age and older (Source: MSDH).

Infant Mortality Task Force

In the 1992 Legislative Regular Session, an act to create the Infant Mortality Task Force was passed. It became effective in April, 1992. The original membership consisted of twenty-five appointed members. It is composed of eleven voting members. The purpose of the Task Force is to foster the

reduction of infant mortality and morbidity in Mississippi and to improve the health status of mothers and infants.

The legislative functions of the Infant Mortality Task Force are:

- ' Serve in an advocacy and public awareness role to the general public regarding maternal and infant health issues;
- ' Conduct studies on maternal and infant health and related issues;
- ' Recommend to the Governor and the Legislature appropriate policies to reduce Mississippi's infant mortality and morbidity rates and to improve the status of maternal and infant health; and
- ' Report annually to the Governor and the Legislature regarding progress made toward the goals stated in the purpose.

DEMOGRAPHICS

The 1998 population estimate by the Census Bureau 2001 for the State of Mississippi is 2,752,092 people. The 1990 Census reported the population as dispersed in 82 counties and 290 incorporated cities, towns, and villages. While 75 percent of the people live in one of the incorporated municipalities, 53 percent live in areas classified as rural by the Census Bureau. Less than 20 percent of the people lived in a city with a population of 25,000 or more, and only one-third in one of 10,000 or more. The State has three standard metropolitan statistical areas (SMSAs): the Gulf Coast (Hancock, Harrison, and Jackson Counties), the Jackson area (Hinds, Madison, and Rankin Counties), and the Hattiesburg area (Forrest and Lamar Counties). The Southhaven-DeSoto County area is in the Memphis SMSA.

According to the 1998 Population Estimate by the Census Bureau, the gender-composition was 47 percent male and 52 percent female. The racial composition was 62 percent white, 36.4 percent African American and one point one percent other races. Persons 65 or older made up 12.2 percent of the population. These data are reflected in the following table.

1998 Population Estimate: 2,752,092

Whites	1,719,483	African American	1,003,173	Other	29,436
Males	837,551	Males	467,022	Male	24,366
Females	881,932	Females	536,151	Females	15,070

Estimated Population Over 65: 336,306

White	248,516	African American	863,373	Other	1495
Males	99,774	Males	32,668		

Females	148,732	Females	53,705		
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Housing

The 1990 Census reported 1,010,423 housing units and an average occupancy of 2.55 persons per unit. By contrast, in 1980 there were 911,627 housing units, with an average occupancy of 2.76 persons. The average household size was 2.75 persons; the average family 3.27. Although there has been marked improvement in income, education, and housing, Mississippi remains well below the national average in these areas. According to most studies, these factors have a significant impact on the health care needs of a population. Therefore, any strategy to elevate the quality of health care in the State should bear these factors in mind.

Employment

Employment increased from 1,281, 000 in November, 1998, to 1,285,000 in October, 1999, a three tenths of a percent increase, while the unemployment rate decreased to three and eight tenths of a percent from four and four tenths of a percent according to the Mississippi Employment Security Commission's AMR-1 Report for November, 1999. The average civilian labor force was 1,268,700 for the 12 month period ending October, 1999 (MSDH State Health Plan, 2000).

Income

Mississippi ranked 50th among the states in both per capita and median family income in the 1990 Census. In 1989, per capita income was \$9,648 while the national average was \$14,420. The median family income for a family of four was \$24,448, more than \$10,000 less than the \$35,225 for the United States (MSDH State Health Plan, 2000).

Education

High school graduation rates rose to 64.3 percent in 1990 from 54.8 percent in 1980, a gain of almost 10 points. Mississippi remains behind the national rate of 75.2 percent. Approximately 14.7 percent of the population over 25 years of age holds a bachelor's degree or higher, compared to 20.3 percent for the United States (MSDH State Health Plan, 2000).

Health Status

The overall health status of Mississippians has improved significantly during the past decade. Death rates in the general population as well as infant mortality rates have declined; more individuals have access to health care; and advances in medical knowledge and technology have led to improved effectiveness in the management of many diseases. Many of the health problems that plague Mississippians are the result of the state's social and economic conditions, and educational levels. Mississippi has the lowest per capita and family income in the nation. Information from the 1990 U.S. Census showed that the state ranks below the national average in the percentage of its population who are high school and college graduates. Mississippi continues to lead the nation in infant death rate, teenage births, births to unwed mothers, and sexually transmitted diseases (especially syphilis).

MINORITY HEALTH STATUS

Mississippi's 1990 population consisted of 35.6 percent African Americans and one percent American Indians, Asians, Pacific Islanders, and others. Fifty-three percent of the state's African American population resides in rural areas. The highest concentration of African Americans live in the "Delta" area of northwest Mississippi, the poorest economic section of the state. Mississippi has historically reported the lowest per capita income (\$9,648 in 1989) and median family income (\$20,136 in 1989) of any state,

with corresponding high unemployment and low educational levels. Poverty dictates a standard of living that diverts all income to the essential needs of food, clothing and shelter. It is difficult for the impoverished to afford good quality health care (Mississippi State Health Plan, 1999). The Mississippi State Department of Health identifies the following factors that contribute to the racial health disparities:

Socio-Economic Status

Mississippi's minority population is disproportionately impoverished. Statistics show that 13.2 percent of Mississippi African American families were below the poverty level in 1989, compared to six and nine tenths of a percent of the white families. The rate of unemployment among the African American population in 1989 was 15.9 percent, compared to five and one tenths of a percent for the white population.

A publication of the Business Higher Education Forum entitled *Three Realities: Minority Life in the United States*, reported that 36 percent of all African Americans are middle class, meaning they have an annual income of \$25,000 or more; 34 percent are at the margin, with incomes ranging from \$10,000 to \$25,000; and approximately 30 percent live in poverty, with incomes below \$10,000. The report further stated that the median net worth for African American households is only nine percent of whites.

Inadequate Access to and Utilization of Health Care Resources:

A lack of health insurance coverage, and inadequacies in coverage limit access to health care providers and facilities. African Americans use hospital emergency rooms and clinics much more often for medical care than do whites. African Americans are more likely to be Medicaid recipients and more likely to be uninsured, due largely to their employment status. Rural

areas, particularly those with a high concentration of poor African Americans, often have very few medical resources. This fact further limits access to primary health care. As of April, 1997, 62 counties or portions of counties in Mississippi were designated as health professional shortage areas for primary medical care.

Lifestyle Risk Factors

Many persons die prematurely for reasons directly attributed to lifestyle practices. In 1997, non-whites were four times more likely to die from homicide and legal intervention than were whites. Many of the conditions mentioned as key health problems for African Americans - heart disease, stroke and hypertension, among others - are greatly affected by lifestyle factors.

Dearth of Minorities in the Health Professions

In 1997, only six and one tenth of a percent of Mississippi's total active physicians were African American and five and seven tenths of a percent were Asians. Based on an estimated non-white population of 1,000,372 (37.1 percent of the total 1995 estimated population), the state has one minority physician for every 1,898 non-white persons. Considering African American physicians, there is only one for every 3,923 non-white persons; 170 or 73 percent of the state's African American physicians were primary care physicians. (Source: Mississippi State Health Plan, 1999).

Cardiovascular Disease (CVD)

Cardiovascular disease (CVD), principally heart disease and stroke is the leading cause of death in Mississippi, accounting for 43 percent of all deaths in 1998. It results from thickening and narrowing of the arterial blood vessels, a process called atherosclerosis, which

begins in childhood and progresses over a lifetime. No other single category accounts for as many deaths. To reduce the prevalence of CVD risk factors in the population, more Mississippians should stop smoking, become more active, lose weight, control their blood pressure, eat a healthier diet, and lower their blood cholesterol level. Adopting a healthy lifestyle at an early age prevents or reduces the risk of CVD. Much of the death, illness, and disability due to CVD is preventable. Population wide actions by individuals, schools, communities, and workplaces working together to create 'heart healthy' environments, policies, and norms will reduce cardiovascular disease (Source: MSDH/American Heart Association).

Mississippi's CVD mortality rate is, and has been for many years, the highest in the nation. In 1997, (the latest year for which comparable national data are available), Mississippi's CVD mortality rate was 30 percent higher than the rate for the entire United States. Below are recent data depicting the growing disparity in CVD between African Americans and whites.

- ' In 1998, 11,845 Mississippians died from CVD:
6,279 deaths among women and 5,566 deaths among men
7,917 deaths among whites and 3,928 deaths among African Americans;
- ' CVD is one of the primary causes of premature mortality: in 1998, one in five CVD deaths occurred in Mississippians under 65 years of age;
- ' African Americans have higher CVD death rates than whites, and men have higher rates than women;
- ' In 1998, rates were 25 percent higher for African American men than white men, and 32 percent higher for African American women than white women; and
- ' Since the early 1980s, African American males and females in Mississippi CVD mortality rates have remained constant resulting in a growing disparity in CVD mortality rates between whites and African Americans;

Coronary heart disease (CHD) and stroke are the two most common forms of CVD, together they

account for 6,553 deaths (55 percent of all CVD deaths) in Mississippi in 1998. CHD and stroke share many risk factors, and the conditions coexist in many people. Stroke is the third leading cause of death in Mississippi. The exact incidence of stroke in Mississippi is unknown, as the state has no stroke register or statewide hospital discharge data system. A very rough estimate, from the 2000 Mississippi State Stroke Report, is that more than 5,000 Mississippians suffer a stroke each year. In 1997, Mississippi ranked seventh highest in the United States, with a stroke mortality rate that was 18 percent higher than the rate for the United States as a whole. Mississippi is one of eleven states in the southeast region of the United States known as the 'Stroke Belt'. For at least fifty years this region has had higher death rates than other United States regions.

Diabetes

Diabetes is the leading cause of heart disease, kidney disease, adult onset blindness, amputations, and stroke. African Americans are twice as likely to develop kidney failure (end stage renal disease), and are more likely to undergo diabetes related amputations of feet/legs than white Americans, with the disease. Diabetes is the fifth leading cause of death for African Americans aged 45-63, and the third leading cause of death for those aged 65 and older. In 1998, Mississippi had the third highest diabetes prevalence in the United States, with a rate that was nearly three times that of Arizona, the state with the lowest prevalence. Diabetes is a major cause of morbidity, disability, mortality, and a major source of health care costs. More than 225,000 residents are now estimated to have diabetes; a third of them are undiagnosed.

In Mississippi, diabetes is a major health concern for African Americans:

- ' According to the 1999 Mississippi Diabetes Report, the 1996 figures showed that 56,253 African Americans had diabetes, another 56,253 had diabetes and without knowledge of it;

- ' African Americans are 1.6 times more likely to develop diabetes than white Americans;
- ' One out of four African American women and one out of five African American men over the age of 50 has diabetes;
- ' African Americans are more likely to develop complications and have a greater disability than white Americans with diabetes. (Diabetes Foundation of Mississippi)

THE MISSISSIPPI HEALTH CARE DISPARITIES ELIMINATION PLAN

Background

Mississippi, like the nation, has experienced disparities in improved health care for segments of the population, specifically for African Americans. The Plan's major focus is on the primary ethnic group statistically impacting Mississippi at this time, African Americans. However, it does not ignore the health care needs of other racial and ethnic minorities in the State. The health care received by African Americans is of paramount concern. It can be used as a baseline for improvement of health care practices as other ethnic groups begin to migrate to Mississippi in larger numbers. Compared to all other ethnic groups, the *American Medical News* reports that African Americans experience higher rates of illness and death from virtually every health condition—from asthma to diabetes to cancer. African Americans in Mississippi “face substantially higher rates of teen pregnancy, births to unmarried mothers, infant mortality, and other health status indicators than do white Mississippians”. Some disparities which impact health care include economic (officials estimate that 21 percent of Mississippians have no health insurance), and geographic factors. For example, the vast majority of the state's physicians, dentists, and other health care personnel are concentrated in the larger cities (State Health Plan, 1999) .

Methodology

In March 2000, the Mississippi State Department of Health held a statewide conference; “Eliminating Health Care Disparities in Mississippi.” Health care providers, consumers, community based organizations (CBOs), other state agencies, colleges and universities, federal, state and local officials and others attended this meeting. The purpose of this conference was to begin serious dialogue in an effort to address health care disparities in the state.

As a result of this conference, the Mississippi State Department of Health applied for and received funds from the United States Department of Health and Human Services - Office of Minority Health, to develop a statewide health care disparities plan, and to address the health care needs of African Americans and other racial and ethnic populations. Mississippi State Department of Health's Office of Minority Affairs, is the official entity with overall responsibility for the management, implementation and development of this plan.

A Statewide Steering Committee was created and a consultant was hired to provide assistance to this office. The purpose of the Steering Committee is to provide guidance and direction in the development of the plan and to oversee the planning process. The State Health Officer invited many of the conference attendees to serve on the Steering Committee. There were also representatives from various state agencies, community-based organizations, health care professionals and providers, consumers, service groups and health care advocates. During the initial meeting of the Steering Committee, it was determined that the information received from the public forums would be categorized and sub-committees would be formed around the various categories.

The following sub-committees, or categories emerged:

Funding/Finance

This committee explored financial barriers to minorities seeking quality health care. It examined funding and financing options available to the state and to individuals. This committee addressed extending the services/programs currently available under federal programs (i.e., Medicaid, Medicare, CHIP) to cover more individuals. It also offered the innovative idea of establishing foundations designed to meet specific (financial/health care)

needs.

Prevention/Education

This committee identified methods to strengthen and enhance existing health education efforts for children and adults. The range of strategies included the following: seeking legislative support for expanding the school nurse program, Mississippi State Department of Health partnering with the Department of Education to revise K-12 curricula; state and community agencies developing partnerships to provide health education and resource information to minority populations;

Cultural Competency

This committee was responsible for identifying methods to increase provider cultural competency and sensitivity to African Americans and other ethnic minority patients. Strategies included incorporating appropriate curriculum changes at the University of Mississippi Medical Center, creating linkages among the State's Medical School, Historical Black Colleges and Universities, community based organizations, the identification of best practices in pipeline programs in middle school by national experts, and the development of and/or expansion of federal and state programs to increase the number of racial and ethnic medical providers.

Access/Availability

This committee's function was to examine barriers that may prevent minorities from accessing health care services; consequently it overlapped into all of the other committees.

This group also addressed the need to develop and strengthen the pipeline for educating minority health care providers, particularly physicians. Other issues explored and addressed included: the lack of awareness of the existence of needed services, discrimination, investigating and monitoring services that target African Americans and other racial and ethnic minority groups, and involving the minority community on the front of the development of programs in which it is the target group.

Legislative

Identified methods and explored opportunities by which to utilize the legislative process to improve access to and availability of quality health care, as well as educate legislators on the health care needs of the citizens.

In addition to the Steering Committee, a public forum was held in each of the nine Public Health Districts. The forums provided a venue for “ordinary” citizens of the state to voice their concerns relative to the overall health care delivery system, and to offer potential solutions that will ultimately lead to the elimination of health care disparities in Mississippi. The forums were held in the location of the State District Health Offices, providing the support necessary for this project, e.g.; facility meeting space, ease of access, etc. The initial forum was held in January, 2001 in District V. (Hinds County), and the final one was held in March, 2001, in District VI (Lauderdale County).

The forums were scheduled for approximately two hours (6:00-8:00 p.m.). The time permitted for questions and comments was limited. Audio taping was conducted when possible and handwritten notes were taken. Information collected from the nine public forums, in addition to data provided by the Mississippi State Department of Health, American Heart Association, American Cancer Society and

numerous research studies and professional papers, have been utilized to develop this Plan.

Traditional and non-traditional information dissemination methods were utilized to “get the word out” about the forums. Press releases were submitted to all local newspapers and Public Service Announcements were placed at various radio stations. Flyers were placed in locations and facilities that are frequently utilized by the general public. Community-based organizations, the faith community, and other organizations with direct access to large numbers of the general public, were contacted and encouraged to attend the forums. Ministers and other identified community leaders were contacted to encourage their congregations and clients, etc., to participate in the forums.

PRESENTATION OF DATA

Public Forums Comments

During the Health Disparity Community meetings held across the State, meeting participants offered comments that have been listed in ten (10) categories. The Strategies and Action Steps for Mississippi are designed based on the information collected in the public forums, input from the Steering Committee meetings, Mississippi State Department of Health data, Mississippi Foundation for Diabetes, national research articles and studies and other sources as identified in this document. If “T” or “CC” is also indicated next to a comment, this indicates that this specific comment is also assigned to the “Trust” and Cultural Competency” category. The comments from the public forums are listed as recorded from raw notes which were collected during the meetings. The categories and comments are listed as follows:

Transportation

1. No transportation to health care facilities;
2. Sometimes I catch the Human Resources van, but you have to call so far in advance to let them know when and where you need to go. Then you have to wait so long for them to come back and

- pick you up;
3. I live in Leake County and I have to go to Jackson, which is 50 miles away, when I am referred to a specialist;
 4. Only two doctors in the town of Walnut Grove;
 5. I live in Madison County and I have to go to Jackson, which is 50 miles away, when I am referred to a specialist; and
 6. I have to travel 20 miles to Jackson and pay someone to take me when I have to pay someone to take me, when I have the money - When you are on a fixed income, sometimes I'm just not able to afford it

Health-Care Cost and Insurance

1. Cannot afford to go to the doctor;
2. Treated like dirt when you don't have any money or insurance to pay for treatment;
3. Some clinics turn people away who do not have insurance and don't have the money to pay;
4. Cannot afford to pay rent and utilities and go to the doctor too;
5. I have to keep a roof over my head and utilities before thinking about going to the doctor or buying some medicine;
6. If I go, cannot afford to buy the medicine because Medicare does not cover the cost of prescription;
7. Can't go sometimes because I don't have the money to pay up front;
8. Doctors will not bill Medicare and wait for their money, so we have to pay up front and then wait to be reimbursed by Medicare;
9. If you don't have the up front money, then you can't go;
10. Most private physicians do not accept Medicaid;
11. Cannot afford the co-insurance for Medicare so I'm left to pay whatever balance Medicare doesn't pay;
12. If I haven't paid my doctor or drug store bill, which is sometimes hard, then I just cancel my next appointment until the time I will have some money;
13. I needed to see a doctor because of liver problems, and because I did not have \$20.00 they would not see me. The same thing happened at the hospital when they found out I had no insurance and no job. The tests were never done, and I'm still sick and see no way to get any help. Madison General also refused to do liver scans because I didn't have any money to pay or any insurance;
14. I was turned away from Carmichael with my two children because we had exceeded the allowed number of doctor visits for one year on Medicaid. Had to wait until 2001 to take my children back to the doctor for chronic illnesses;
15. Since Medicaid does not pay for my medicine most of the time I just do without it;
16. Since Medicare does not pay for my medicine, if I know someone who is taking the same medicine, I will borrow some of theirs until I can get mine and then pay them back;
17. Since Medicaid does not pay for my medicine, I have to use home remedies;
18. Inherited a little money and my SSI benefits were cut off until the money was spent and when the benefits were cut off, so was my Medicaid and I had to spend all my money paying for medicine and doctors until it was all gone-the only thing I'm allowed to have under SSI is a burial account

- and that is limited;
- 19. Many single parents cannot afford services and do not qualify for CHIP;
- 20. Patients are not able to purchase medications;
- 21. Insurance companies should pay for more preventive care;
- 22. Statewide clinics are needed to provide low or no costs medications;
- 23. There is always a shortage of funding and sharing of resources;
- 24. Not able to pay for treatment; and
- 25. High cost of care

Education/Awareness/Training

- 1. Educate the existing community providers regarding health care needs;
- 2. Education/information needs to be consumer friendly;
- 3. Re-train community lay people on health care issues including when to refer to medical providers;
- 4. Failure of consumer to follow medical orders;
- 5. More education/information on appropriate self-care ;
- 6. Need for culturally appropriate educational materials in the African American community;
- 7. More training of community lay persons to work directly in the community to provide information to under served populations (encouragement of community activism);
- 8. More information on AIDS awareness;
- 9. More education on signs and symptoms of illnesses and diseases is needed;
- 10. More training on community self-sufficiency should be provided;
- 11. The reading level of many of the educational materials is too high;
- 12. Information provided on prescriptions by providers is too technical; and
- 13. Prescription labeling information is not understandable

Health-Care for Women

- 1. Women's health care issues not of great concern, particularly menopausal women;
- 2. Need for support groups;
- 3. Many women are self-treating for illnesses that require medical care., e.g. breast cancer
- 4. Insensitive to my issues

Health-Care for Children

- 1. Not knowing that their children could be enrolled in the CHIPS program, I thought their mother had to do it, and she is not at home with them;
- 2. Did not know the CHIPS program existed;
- 3. Care for children while in hospitals, parents get stressed if there are other children at home, cannot afford cost for care taking;
- 4. Lack of adequate children's prevention programs;

Trust

- 1. Suspect that long waits are possibly a result of racial socioeconomic attitudes;
- 2. Fear of the unknown; and

3. Lack of networks that can be trusted

Cultural Awareness and Sensitivity

1. Providers need cultural sensitivity training;
2. Insensitivity of providers;
3. Lack of adequate programs for Hispanic population (language barriers)

Health-Care Providers

1. The hospital staff is incompetent and the local doctors seem to be the worse of the lot (T);
2. Too many people have died from being mis-diagnosed by these local doctors (T);
3. They wait too long to refer you to a specialist, and when they do, most of the time, it's too late;
4. The hospital is dirty and the service is poor;
5. Have gotten to the hospital and the emergency room was closed;
6. Waits are too long in doctor office/clinic;
7. Turf wars existing among agencies interfere with consumer care;
8. Too much bureaucracy in place is disillusioning;
9. Hours of providers' offices (including MSDH) are not consumer friendly;
10. Health care providers are incompetent (T);
11. Health care providers need customer service training;
12. Providers talk down to patients (CC, T);
13. Providers do not honor confidentiality; (T)
14. Current providers sometimes do not honor medicines from fee programs (say they have not heard of the medications);
15. Medicaid providers report false diagnosis to get more money from insurance company (T);
16. Poor record-keeping; (T)
17. Providers do not look at you when talking to you and do not touch you (CC, T);
18. Providers do not communicate with each other;
19. Health care facilities do not inspire confidence (dilapidated buildings);
20. Reverse discrimination practiced by some providers;
21. Use mobile units;
22. Local health care providers need to provide more comprehensive care;
23. More after-hours clinics are needed;
24. Local providers left out on funding when special programs become available;
25. There is not enough collaboration among providers and consumers;
26. Mental/emotional illnesses ignored, and the correlation of these illnesses to not seeking medical care;
27. Physicians are insensitive to time spent with patients (not adequate)

Health-Care Consumer

1. Many people are not seeking health care
2. Consumers ignore symptoms due to the fear-factor-cost? How will I handle this? Why find out if I cannot pay for it;

3. Frequent address and phone number changes of consumers;
4. Some consumers cannot get the medication prescribed (not available);
5. Consumers oftentimes cannot afford medications prescribed, thus cannot follow treatment protocol;

Health-Care for Elderly

1. Lack of adequate and appropriate elder care, e.g. Alzheimer disease

Job-Related Problems

1. Not employed and can't even qualify for Medicaid;
2. Earn too little to afford health insurance on the job and at the same time, make too much to qualify for Medicaid;
3. When I was laid off my job, I lost my health insurance benefits;
4. The health insurance is available, but is too expensive for me to buy coverage for my entire family;
5. In order for us, my wife and children, to get some kind of health insurance, she had to say we were separated in order to qualify the children for Medicaid;
6. Factory jobs do not provide health insurance;
7. Some working people cannot get time off from work, with or without loss of wages; and
8. Provide health care services in the factories and plants

Legislation

1. Legislation is needed to prohibit doctors from receiving kick-backs;
2. Re-institute old public health model "home visits" from doctors;
3. Find ways to include locals in decision making regarding health care issues;
4. Eliminate pre-approval regulations;
5. Lack of continuity of care; and
6. Lack of maintenance of programs-"here today, gone tomorrow"

The following tables represent the efforts of the Health Care Disparities Steering Committee to address disparities in health care in Mississippi. This is considered to be the *first draft* of what will be the blueprint for improving the health of the citizens of the State of Mississippi.

STRATEGIES, ACTION STEPS & DESIRED OUTCOMES

CULTURAL COMPETENCY

Strategies	Action Steps	Desired Outcomes
<p>Prepare medical, health care and human service professionals for cross-cultural relationships with their patients to learn to respond to the unique needs of their patients;</p>	<p>Encourage The University Medical Center, other major state funded Institutions of Higher Learning and professional licensing bodies to institutionalize practices and procedures to strengthen their ability to fully serve and effectively address the health care needs of all of the state's racial and ethnic health care consumers by:</p> <p>Establish partnerships among major state Institutions of Higher Learning professional licensing organization;</p> <p>All State Health and Human Service agencies, and community groups identify, develop, review and approve core competencies to ensure that the health care and human service needs of racial and ethnic minorities are addressed;</p> <p>Expand all medical/health care and human service provider education programs to address specific core competencies as required course work in their training curriculum, so that by the year 2010, cross cultural training is institutionalized within these systems; and</p> <p>Institutionalize the philosophy of cultural competency throughout all of the state's education and training institutions.</p>	<p>A more culturally competent, sensitive, informed health care provider population;</p> <p>A healthier, more medically compliant, trusting MS health care consumer population;</p> <p>A better informed and less alienated health care consumer population; and</p> <p>Improved effectiveness in addressing racial/cultural biases, improved clinical outcomes, and reduced the racial and ethnic health care disparities.</p>

Require all practicing physicians, nurse practitioners, nurses, social workers, and all other health and human service providers to earn continuing education units in cultural competency on a yearly basis for five consecutive years, after which the CEUs will be required every two years, or as determined by their licensing organization.	<p>The University Medical Center, other major state funded Institutions of Higher Learning and professional licensing bodies should institutionalize practices and procedures to strengthen their ability to fully serve and effectively address the health care needs of all of the state's health care consumers;</p> <p>Professional health and human service organizations should mandate within the scope of their policies and procedures a requirement of participation in and completion of approved core cultural competencies to remain a duly licensed practitioner in the state of MS.</p>	More culturally competent, sensitive, informed health care providers; a healthier, more compliant, better informed and more trusting Mississippi health care consumer population; thus improving the health status of Mississippi residents; and better health status and/or health care for African Americans and other minorities in MS.
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CULTURAL COMPETENCY (cont'd)

Strategies	Action Steps	Desired Outcomes
Increase the number of under-represented minorities in Mississippi's health professions through support (financial and otherwise) for their recruitment in medical/health care and human service preparatory or "pipeline" programs beginning at the elementary school level and continuing through college.	<p>Identify best practices in medical/health care and human service preparatory (pipeline) programs and the factors which contributed to their success to foster replication;</p> <p>Fund evaluations of science and mathematics programs so that students can be tracked over time;</p> <p>Develop new and innovative medical/ health care and human service preparatory programs to recruit, support and retain African Americans and other racial and ethnic college students.</p>	<p>Successful programs can be easily identified and replicated, thereby increasing the pipeline pool of students;</p> <p>Increased number of African Americans and other racial and ethnic minorities remaining in state to practice.</p>

<p>Increase the number of under-represented minorities in Mississippi's health professions</p>	<p>Federal and state governments should develop partnerships to create new and innovative medical/health care and human service preparatory programs, to recruit support and retain African Americans (and other racial and ethnic minority) college students.</p>	<p>Stronger pipeline programs - produce better prepared students;</p> <p>Tracking capability improves recruitment opportunities for in-state students;</p> <p>Medical schools should aggressively recruit well prepared in-state racial and ethnic college graduates for medical school; and</p> <p>More African American and other racial and ethnic minorities will remain in state for medical school.</p>
<p>Prepare J1 physicians to meet the health care needs of the state's racial and ethnic minorities;and other residents.</p>	<p>Require all J1physicians to complete specific core cultural competencies to ensure that they understand these needs and are better prepared to address the needs of racial and ethnic minorities in Mississippi.</p>	<p>More culturally competent, sensitive informed health care providers to serve the state's racial and ethnic minorities;</p> <p>Improved medical compliance;</p> <p>More accepting and trusting racial and ethnic health care consumers;</p> <p>A better informed and less alienated racial and ethnic health care consumer population; and</p> <p>More sensitive J1 practitioners.</p>

PREVENTION/EDUCATION

Strategies	Action Steps	Desired Outcomes
Develop and strengthen the Health Education Curriculum for K-12 in Mississippi public school districts.	<p>Mississippi State Department of Health and the Mississippi Department of Education, Public School Districts, advocacy organizations, parents, and other community organizations should develop a partnership for legislative enforcement of existing and or newly created laws that require health education to be taught in Mississippi public schools;</p> <p>Mississippi's State Department of Education and State Department of Health should adopt/enforce policies that mandate the development and/or implementation of an existing and approved health education curriculum.</p>	<p>Health Education is required in every school;</p> <p>Better health educated children and youth in Mississippi;</p> <p>Healthier students and families; and</p> <p>Strong alliances such as these create stronger public school systems</p> <p>Stronger collaboration and coordination between these state agencies =More informed parents and school aged children and youth=Healthier Mississippi population</p>
Create opportunities for citizens to become involved in health planning for their respective communities.	The Office of Minority Affairs should create partnerships with faith based organizations and other non-profit organizations to create "community health education and resource networks" to educate under-served and/or under-represented racial and ethnic minority communities.	<p>Local communities trained and empowered to provide health and other resource information to the citizens;</p> <p>More knowledgeable and healthier local population; and</p> <p>Citizens become empowered to take responsibility for their health status</p>
Expand the School Nurse Program to provide nurses in all public schools and/or school districts.	Mississippi's State Department of Health, Department of Education, Division of Medicaid, community health advocacy organizations, parents and community and consumer groups coordinate efforts with the legislature to expand and adequately fund the school nurse program.	Prevention of and intervention in illness, increasing average daily attendance.
Expand the School Nurse Program to include Health Education.	Mississippi's State Department of Health, Department of Education, Division of Medicaid, community health advocacy organizations, community and consumer groups coordinate efforts with the legislature to expand and provide adequate funding for the school nurse program.	Increased knowledge of how to become more responsible for individual health care, thus improving overall health status of state.

Educate citizens to become involved and participate in clinical research trials;	Hold public hearings to provide information to consumers on clinical trial research; and Encourage the medical/health provider community to create/utilize existing citizen's group to participate in appropriate activities related to clinical trial research.	More minority citizens enrolled in clinical research trials; thus improved capability to address health care disparities.
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ACCESS/AVAILABILITY

Strategies	Action Steps	Desired Outcomes
Increase the number of underrepresented minorities in Mississippi's health professions	University Medical Center, the Mississippi State Department of Health, the appropriate Mississippi State agencies should create an infrastructure to recruit, support and retain African American physicians in the state; Develop recruitment/retention incentives to encourage graduating African American medical students to remain in and/or return to the state.	Improve health access for racial and ethnic minorities who tend to choose health care providers from their own racial and ethnic group.
Increase the number of minority researchers.	Develop research partnerships among the federal agencies, major Historical Black Colleges and Universities and the University Medical Center that provide opportunities for funding and leadership roles for African Americans in research studies; The Mississippi Legislature, Institutions of Higher Learning and Federal Government should provide adequate funding to strengthen Historical Black Colleges and Universities research capacity, through the existing programs and by creating new, innovative and appropriately financed funding opportunities in minority research.	Address issues directly related to African Americans and other racial and ethnic minorities. Increase the scientific and research pool of African Americans and other racial and ethnic minorities. Increased participation of African Americans and other racial and ethnic minorities in research studies.

Establish a “Center of Excellence”, that will create/identify practical strategies to eliminate racial and ethnic disparities in the health care system.	<p>Mississippi State Department of Health, University Medical Center and Jackson State University should create a partnership to address this issue, utilizing expert faculty within their respective systems and national experts.</p> <p>Develop and/or strengthen the linkages between research entities and change agents (private/public policy makers, community health centers, Area Health Education Center programs, community based programs, professional organizations, local level religious groups, media, etc.)</p>	<p>Identification of uniform standards to address barriers and solutions to change.</p> <p>Creation of cross-cultural networks that include grassroots community participation to provide input and monitoring on policy making and program development and implementation.</p>
Establish a Health Resource Clearinghouse within the state.	State health and human service agencies combine resources to create the clearinghouse.	<p>More accessible appropriate information available to general public.</p> <p>A better informed and more health conscious public.</p>

FUNDING/ FINANCE

Strategies	Actions	Desired Outcomes
Create private/public partnerships to provide coverage.	Government and private entities and advocacy groups create partnerships to investigate and implement methods to lower deductibles and/or cost of insurance.	<p>Fewer uninsured families, healthier Mississippi population.</p> <p>Reduction in morbidity rates.</p>
Increase the availability of insurance for the uninsured in the Medicaid, Medicare and private insurance companies.	Mississippi’s State Department of Health, Department of Human Service, Department of Insurance, and community advocates coordinate public forums to discuss modifying and unifying programs such as Medicaid and Medicare and private insurance companies to expand coverage.	Change in existing government and private pay coverage policies that will allow coverage for the uninsured.
Increase the percentage of coverage by CHIP.	Mississippi State Department of Health collaborate with Department of Human Service and Medicaid to provide employees with information on Children’s Health Insurance Program (CHIP) eligibility criteria.	Unified requirements and benefits for various government programs to lay a foundation for “universal coverage”.

Extend the income range for eligibility allowing more coverage of “working poor” children, families and elderly to participate.	Advocate for Legislature and the Mississippi Division of Medicaid to create and/or expand laws to address this concern.	Increased number of children and families covered for a healthier Mississippi population.
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LEGISLATION

Strategies	Actions	Desired Outcomes
Creation and passage of a Patient’s Rights Bill.	Educate legislators on Patient’s Rights issues.	HMOs and insurance accountable for denying access to quality care.
Increase the number of medical/health care consumers on provider boards, e.g., State Medical and Nursing Boards.	Passage of law to increase the number of medical/health care consumers on provider boards, e.g., State Medical and Nursing Boards.	Better programs will be developed and will be user friendly.

Increase/enhance community health outreach activities of hospitals and state operated and/or funded health care agencies.	<p>Create legislation requiring specified community health activities for the under-served populations;</p> <p>Create legislation requiring hospitals and health care agencies to include consumers' input when planning community health programs.</p>	<p>Stronger community buy-in on locally sponsored activities;</p> <p>Better relations among consumers health care providers and policy-makers i.e., hospitals, physicians, nurses, state health/human services agencies;</p> <p>Healthier Mississippi families, children = healthier Mississippi communities.</p>
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IMPLICATIONS AND CONCLUSIONS

We have enough evidence that disparities in health care do exist. It is common knowledge and is suggested in one of the strategies by the Agency for Healthcare Research and Quality (AHRQ), that the first step to making change is acknowledging that change is necessary.

Now that we know disparities exist, the next question is, “Do we really want to change those disparities?” We have presented reasons and justifications for change that encompass an entire nation. The goal is to impress upon policy-makers and those in positions of authority, the benefits to be received by all citizens of the United States. Significant philosophical changes in our perspective in reference to ethnic and racial “minorities” are necessary. The evidence of disparities is well documented. These disparities distort the image of the entire country, resulting in a less than favorable picture of not just certain ethnic groups but all Americans. It is incumbent upon the power brokers of this country and specifically, Mississippi, to take this issue seriously. Mississippians can begin by taking an inventory of how they perceive ethnic minorities and whether they believe it is a worthwhile endeavor to eliminate all vestiges of discrimination and fight for equality for all people regardless of race or ethnicity. This process demands the adaptation of honesty and an elimination of hypocrisy. This entails believing what we say and doing

what we believe.

Practitioners are more likely to serve those of their own race or ethnic group; minorities are no exception. However, African American physicians are more likely than others to treat patients who are African American and/or on Medicaid (Nickens . Herbert W., 1997). Likewise, Latino physicians are more likely than others to treat patients who are Latino and/or uninsured (New England Journal of Medicine, 1996). Minorities are under represented in the health professions. According to the Agency for Healthcare Research and Quality, enrollment of racial and ethnic minority groups has continued to decline over the past several years. While many medical schools have taken pro-active steps to increase minority representation, their efforts have “come under fire in California, Texas, Louisiana, Mississippi, Washington and Florida, where the use of race-based criteria for admission into state or federally supported institutions has been prohibited” (USDHS, Agency for Healthcare Research and Quality, *Strategies to Reduce Health Disparities* Conference, 2001). In addition, it was found that Louisiana and Mississippi applications for minorities to enter medical schools declined 17 percent (2.3 times more than the national average). Even more alarming is that the percentage of applicants accepted declined 27 percent (seven times that of the national average). There was also a drop in minority matriculation by 26 percent (six times greater than the national average). This data makes it obvious that we have a “tug of war” going on in this country where some are fighting for change and others are fighting to keep things as they are and herein lies the dilemma. Eliminating disparities is a stated national priority and as a result, the time is right for strong government action. The strategies identified at the federal and local levels in this report require commitment and partnership across government agencies, between federal and state governments, provider institutions and community organizations.

A strong argument has been established for cultural competence training and implementation, however, unless the desire to change is present, this too will become another idea that is minimized out of existence. The difference now is that we have the issue of a pending demographic shift which necessitates change more than ever before. This should motivate those who have not understood the need to change prior to now.

Another motivation for change at the state level is to make sure we meet legislative, regulatory and accreditation mandates. As an enforcer of civil rights law and a major purchaser of health care services, the federal government has a pivotal role in ensuring culturally competent health care services. Title VI of the Civil Rights Act of 1964, mandates that no person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. Organizations and programs have multiple, competing responsibilities to comply with federal, state and local regulations for the delivery of health care services. The Bureau of Primary Health Care, in its *Policy Information Notice* 98-23 (8/17/98), acknowledges that:

“Health centers serve culturally and linguistically diverse communities and many serve multiple cultures within one center. Although race and ethnicity are often thought to be dominant elements of culture, health centers should embrace a broader definition to include language, gender, socio-economic status, housing status and regional differences. Organizational behavior, practices, attitudes and policies across all health center functions must respect and respond to the cultural diversity of communities and clients served. Health centers should develop systems that ensure participation of the diverse cultures in their community, including participation of persons with limited English-speaking ability, in programs offered by the health center. Health centers should also hire culturally and linguistically appropriate staff” (USDHS, Agency for Healthcare Research and Quality, *Strategies to Reduce Health Disparities* Conference, 2001).

We are increasingly reminded that cultural knowledge and understanding are important to personnel

responsible for quality assurance programs. In addition, those who design evaluation methodologies for continual program improvement must address hard questions concerning the relevance of health care interventions. Cultural competence will have to be inextricably linked to the definition of specific health outcomes and to an ongoing system of accountability that is committed to reducing the current health disparities among racial, ethnic and cultural populations (AHRQ, Conference, 2001).

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APPENDIX

STRATEGIES - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The following strategies were presented at a conference sponsored by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ), on April 4-6, 2001, in Tucson, Arizona. The conference titled - “Strategies to Reduce Health Disparities, A Comprehensive Workshop for Senior State, Local, and Tribal Health Officials,” presented a holistic approach to remedying healthcare disparities. The strategies are presented to indicate the national focus and to evaluate the direction taken by local participants in the “Mississippi Disparities Elimination Planning Project.”

Strategies for Reducing Racial and Ethnic Disparities in Access to and Use of Medical Care

(Robert M. Mayberry, M.P.H., Ph.D.)

- ' Acknowledge racial/ethnic disparities.
- ' Build an appropriate knowledge base for better understanding and effective interventions.
- ' Target resources appropriately to vulnerable groups (e.g. low-income, uninsured, chronically ill).
- ' Develop community-private-public partnerships (e.g. immunization, cancer screening).
- ' Establish and promulgate accountability measures (e.g. for color-blind universal access).
- ' Hold medical care systems/providers accountable for results (particularly Medicaid/Medicare and VA providers).

Strategies for Increasing Access to Health Care Coverage

Micro Level Strategies:

- ' Increase the federal poverty level requirements of Medicaid and other government-funded programs to cover more “working poor.” Expand Medicaid and State Children’s Health Insurance

Program (S-CHIP) coverage to include “legally permanent residents.”

- ‘ Unify the requirements and benefits of various government-funded programs (Medicare, Medicaid, S-CHIP, and the Federal Employees Health Benefits Program) to lay a foundation for universal health care or a single-payer health care system.
- ‘ Initiate a public relations campaign to influence the opinion about Medicaid and health care in general stressing health care as a right, and to remove the stigma associated with publicly funded programs. Incorporate these messages into community-based outreach efforts to enroll eligible families in Medicaid and S-CHIP.
- ‘ Provide states with resources to extend coverage through enhanced flexibility in implementing Medicaid waivers, by identifying and disseminating best practices in extending coverage, and through ongoing monitoring and evaluation of innovative initiatives. Data from model programs should be collected and analyzed by race and ethnicity.
- ‘ Simplify Medicaid and S-CHIP enrollment processes. For example: Implement presumptive eligibility determination, used mail-in applications, end the requirement of face-to-face or in person interviews, and end the requirement of quarterly status reports.
- ‘ Provide appropriate language assistance for applicants and beneficiaries of any Medicaid or other publicly funded programs.

Micro Level Strategies:

- ‘ Evaluate and support partnerships between local government and community agencies in outreach and enrollment in publicly funded programs. Many states and counties are beginning to formalize these relationships (particularly in S-CHIP programs) and these efforts must be evaluated.

Community outreach and enrollment efforts should be studied to identify models that work and to replicate successes.

- ' Collect community-level data on the uninsured by race, ethnicity, geographic area, and other demographic characteristics. This data can be used to mobilize communities to organize for universal health care.
- ' Support community organizations to monitor the state and county agencies to ensure that adequate outreach is being targeted to the limited English proficiency (LEP) community appropriate language assistance is being provided to the LEP population, and that they have adequate access and are receiving health care services.
- ' Establish forums for meaningful community input in health policy and planning so that government funded initiatives are appropriately designed and implemented to meet the needs of the targeted community. * *(The Mississippi Disparities Elimination Project for which this report is being written addresses this strategy);*
- ' Encourage local providers to identify individuals eligible for public programs and assist them in applying for benefits;
- ' Encourage local providers to identify individuals eligible for public programs and assist them in applying for benefits.

Strategies for Increasing Primary Care Capacity in Minority Communities

Macro Level Strategies:

- ' Increase the number of underrepresented, minorities in the health professions through investments in pipeline programs. Identify best practices in pipeline programs and the factors which contributed

to their success to foster replication. Fund evaluations of pipeline programs so that students can be traced over time.

- ' Increase mentoring programs at the Health Resources and Service Administration (HRSA), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC) and other federal agencies. Support internship programs to decrease racial and ethnic health disparities such as the Association of Schools of Public Health and Centers for Disease Control Internship and Fellowship Program.
- ' Collect data on the impact of eliminating affirmative action on training of minorities in medical professions.
- ' Increase the reimbursement rate for Medicaid and S-CHIP to encourage the participation of more providers in under served areas. Provide incentives such as tax credits to make up for inadequate reimbursement rates.
- ' Create financial incentives for Managed Care Organizations (MCOs) to reimburse primary care providers who practice in neighborhoods with a primary care shortage at a higher rate than the average primary care providers.
- ' Strengthen existing efforts and create new opportunities through HRSA to support primary care improvement in minority communities (i.e., National Health Service Corps, Bureau of Health Professions, etc.).
- ' Establish more scholarship programs in the health professions.

Micro Level Strategies:

- ' Engage community institutions, K-12 programs, and healthcare providers in pipeline and mentoring

programs.

- ' Improve patient-provider communication among minority and LEP patients.
- ' Conduct longitudinal studies and evaluations to gauge the progress and measure the success of pipeline programs.
- ' Link academic institutions and health provider institutions so that training health professionals develop real-world competencies and are able to provide appropriate care to minority communities.

Strategies for Increasing Institutionalized Cultural Competency

Macro Level Strategies:

- ' Mandate standards on culturally and linguistically appropriate services to ensure cultural competence in health care. Consider making the draft standards recently issued by the Office of Minority Health (“CLAS”) mandatory.
- ' Establish Managed Care Organization (MCO) contract language which the Health Care Financing Administration (HCFA) could require in all Medicare and Medicaid contracts to ensure linguistic access to all services and, at a minimum, that MCOs comply with Title VI and recent Office of Civil Rights (OCR) rulings.
- ' Establish minimum standards to compel training institutions to incorporate cultural competency in academic requirements.
- ' Adjust reimbursement rates to reflect any increased costs associated with CLAS requirements.
- ' Conduct periodic “walk-through” of facilities by regulators for compliance with cultural and linguistic access standards.

- ' Mandate consumer participation on governing boards of provider institutions and managed care organizations through the Joint Commission on Accreditation of Healthcare Organization (JCAHO) and the National Committee for Quality Assurance (NCQA) accreditation process.
- ' Strengthen the existing linguistic measures in the Health Plan Employer Data and Information Set (HEDIS).

Micro Level Strategies:

- ' Require providers and institutions to develop and implement clear CLAS policies and provide ongoing training for all staff, especially front line staff who have patient contact.
- ' Identify and disseminate best practices in care delivery for LEP patients to facilitate replication of these efforts.
- ' Require that publicly funded hospitals and managed care organizations hire and contract with bilingual providers/interpreters who can meet the needs of their patients.
- ' Foster partnerships between providers and ethnic organizations to assist in adapting their service delivery to meet the needs of various cultural groups.
- ' Encourage health care institutions to partner with community organizations to develop language banks (or pooled interpreter services), staff lists, and language assistance policies to ensure adequate access for the LEP population.